catalepsy no pain is felt. In lethargy the respiration is regular and moderately deep; in catalepsy the breathing is slow, superficial, and irregular. When a magnet is used in the vicinity of the epigastrium an apnœa results for some seconds. In lethargy the blood-vessels of the extremities dilate; in catalepsy they contract, as is shown by the plethysmograph. When a sphygmograph is placed upon the carotid in a state of lethargy, a strong progressive augmentation of the height of the pulse-curve takes place, if a magnet approaches the head. It has no effect on the pulse in catalepsy.—*Rivista sperimentale di freniatria e di medicina legale.* An. viii, Fasc. iii. ISAAC OTT, M.D.

b.—GENERAL PATHOLOGY OF THE NERVOUS SYSTEM.

INJURY TO THE HEAD; SLIGHT CONCUSSION; RAPID ACCESSION OF COMA AND DEATH.—The patient, æt. fifteen, a rather anæmic-looking boy, was brought to the London Hospital on April 29th. He was said by his friend to have taken a dive in the river, striking his head with violence on the bottom. The symptoms agreed with this account, the patient being on admission in a dull and semi-unconscious state, complaining only of headache, and apparently suffering from slight concussion of the brain. He was left at rest with ice to the head, and three days after admission seemed nearly well and wanted to go home. He would probably have been discharged had no further symptoms occurred the next day. The same night he again was attacked with intense headache. The pupils were dilated; no paralysis was present; speech became an evident exertion to him, and on bidding he performed movements, such as protruding the tongue, etc., after an interval. There was now noticed for the first time a slight purulent discharge from the left ear. One of the patients in the ward was told by the father of the boy on this day that a discharge had been present before admission, for which he had been under treatment outside, and also that he had previously suffered for some time with headache. This was the first intimation that the boy had been out of health, notwithstanding inquiries made of the friends. Symptoms next day were increased, and the patient died on the fifth day after admission, having been comatose about an hour before death occurred. The condition of the discs, just before death, pointed to a commencing neuritis; the margin presented a woolly appearance. On post-mortem examination the dura mater was found adherent to the brain, posteriorly. In the left parietal and temporal region was a blackened spot covering a large abscess cavity, reaching as far as, though not entering, the ventricular space, and containing a very considerable quantity of very foul pus. The temporal bone was necrosed, and pus found between that bone and the dura mater. The coincidence of the injury and the brain mischief is obviously of much interest, as supposing the boy had been allowed to go home and then died, it would have been impossible to convince his friends that his death was not due to the injury, and that there had not been culpable want of care. Service of Mr. James Adams.—*Brit. Med. Jour.*, Sept. 16, 1882.

A CASE OF ALLOCHIRIA.—Ferrier reports (*Brain*, Oct., 1882), a case of severe cranial injury, causing prolonged unconsciousness, followed by motor disorder of a combined ataxic and hemiplegic character, from which the patient had only partially recovered at the time of his discharge, together with the temporary, remarkable perversion of sensory localization, to which Oberstine has given the name allochiria (*Brain*, July, 1881), a condition characterized by the erroneous reference of sensory impressions to the corresponding part of the other side of the body. In the case reported, besides the transposition of sensation, there was transposition of the reflex reactions. Tickling of the sole of the foot caused retraction of the other, while the foot actually tickled remained perfectly still; so, also, tickling of the inside of one thigh caused flexion of the other.

NOTES ON TWELVE CASES OF BRAIN TUMOR.—Chas. K. Mills, M.D., of Philadelphia, in a paper read before the American Neurological Society, gives the following recapitulation of his studies on twelve cases of brain tumor, from which we extract the following:

Etiology: history of syphilis in three cases; history of syphilis and traumatism in five cases; history of traumatism alone in one case; tubercular history in two cases; no history in one case.

Pathological Anatomy: gummata in six cases; fibromata in two cases; tubercle in two cases; not determined in one case.

The location of the twelve tumors were as follows: antero-parietal region, 3; Rolandic region, 3; parieto-occipital, 1; temporo-sphenoidal lobe, 1; cerebellum, 2; pons Varolii, 2. The author concludes with remarks on the local diagnosis of brain tumors.

He considers that the symptoms which point conclusively to the existence of intracranial tumor are: headache, pain on percussion of the head, vomiting, vertigo, mental disturbances, hyperæsthesia, choked discs or optic neuritis, elevated temperature of the head, constipation. *Headache* was present in every case. In ten cases, more or less headache was present all the time. The usual type of headache from intercranial tumor he describes as a continuous pain, sometimes of persistent severity, and generally with exacerbations of great violence. In two instances the pain was greatest in the region of the head nearest to the seat of growth. He refers to Callender's observation that cortical lesions are more frequently accompanied by localized pain than lesions of deeper parts. *Percussion of the head* elicited an intensified pain in the region corresponding to the location of the tumor in three